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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 1/16/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Intrathecal Pump Replacement, JO735 x 102, J2271 x 102, J3490 x 102, 95990 x 4 through 2/28/15.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Pain Management & Anesthesiology

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	**(Agree) X**
Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
An incomplete history is provided. This individual has failed back syndrome and has had an intrathecal catheter and drug delivery system for an unknown period of time. The pump was replaced on 8/14/14 and there are notes showing a refill on 11/08/14. The recent notes describes severe neck pain and a cervical steroid injection was recommended. The only mention of the low back pain is in the assessment where there is mention of failed back surgery syndrome, chronic pain syndrome, lumbar, and lumbago, status post implant Flowonix Prometra morphine pump August, 2014.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

Opinion:
I agree with the benefit company's decision to deny the requested intrathecal pump refill and reprogram. Rationale: ODG require evidence of efficacy of intrathecal opiates to maintain that modality. There is no mention of efficacy at any time or at any place in the records presented for review. The records concentrate on cervical pain and the pain ranges between a 4 and 8 and there is no mention of lumbar pain, nor the efficacy of the intrathecal drug delivery system.

ODG are not met for the requested procedure due to inadequate documentation of efficacy of the implanted catheter and pump.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)